COMMENTARY

Does emergency medicine in the UK have a future?

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Emergency medicine in the UK may not survive the current reorganisation of emergency services

Emergency medicine in the UK has undergone many changes recently. This article describes how these changes, and the current reorganisation of emergency services (and of acute hospitals), may threaten the future of this specialty.

REBADGING

In 2004, members of the British Association of Accident and Emergency Medicine voted to change the name of their specialty from accident and emergency medicine to emergency medicine. The reasons for this included a desire to use the same title as that used in other countries, and because many hoped that UK emergency departments might come to resemble their Australian counterparts (where emergency departments have accredited emergency physicians on duty at all times and where definitive care is provided for most medical emergencies).

However, some were concerned about losing the title ''A&E'', which was a term widely understood by the general public and by healthcare purchasers. Others feared that the new title would signal further disinterest in the trauma side of the specialty.

At the same time a new specialty was being developed—acute medicine. Specialist acute physicians had become necessary to lead the medical assessment areas that had developed in most hospitals, and to compensate for the many cardiologists, gastroenterologists and respiratory physicians who were no longer interested in the emergency element of their specialty.

The unfortunate consequences of these developments are now becoming apparent. Many outside observers now believe that emergency medicine deals principally with medical emergencies, and that emergency medicine and acute medicine are synonymous. This in turn has led to a flawed (but widely quoted) concept of what support specialties an emergency department requires.[1] Furthermore, the public is also now confused about exactly what services an emergency department offers. For example, is an ankle injury an emergency?

MINOR TRAUMA

Minor trauma is a deeply misleading term because it includes all trauma that is not major[i]—that is, many injuries which are serious, or which are important because of their frequency and their social and economic effect. Minor trauma comprises 60% of attendances at emergency departments, and includes most conditions for which emergency physicians can provide definitive care. It is therefore a important part of emergency medicine.

Until about 10 years ago, this element of our work was valued, and the involvement of interested doctors led to useful research in this area. Then, mainly to resolve workload problems rather than to improve quality, emergency departments started employing nurse practitioners to see minor trauma. It is to the discredit of our specialty that we allowed such an important part of our work to be managed by practitioners who had no nationally-agreed field of practice and no national system of examination or reaccreditation. Also, there was little evidence to support this development. Published data shows only that nurse practitioners can manage a limited range of minor conditions as well as very junior doctors. Hardly a gold standard of care.

The disinterest of many emergency physicians in minor trauma was further emphasised in *The Way Ahead* document published in 2005 which stated, ''Minors … it is likely that in most departments over the next 5 years this area will become nurse led and run''.[2]

PAYMENT BY RESULTS

Since April 2006, emergency departments have been paid according to the number and nature of the patients they treat. This seems perfectly reasonable, but many Primary Care Trusts are now paying more for their hospital emergency service than they used to, and as a result are looking at ways of ''gate keeping''—that is, restricting the number of patients who enter emergency departments. This has lead to the concept of urgent care centres, where ambulant patients seeking emergency care are triaged by staff employed by the Primary Care Trust. Certain diagnostic groups are allowed through into the emergency departments, but many are seen by onsite general practitioners or nurse practitioners. In this way the PCTs can control expenditure, and many patients with minor trauma who would previously have been managed in emergency departments are no longer seen there. The result of this is that the case-mix of emergency departments is being restricted, and this diminishes our specialty. The government perspective on how urgent care centres might work (including the limited role for emergency departments) can be found in a recently-released discussion document.[3]

LOSS OF INPATIENT SPECIALTIES

Traditionally, emergency departments in the UK have received an undifferentiated case-mix, and have either provided definitive care or have referred on to hospital specialties. We may have wished to mimic the Australian model of emergency care, but the truth is that very few emergency departments in the UK have the staff or facilities to provide continuing inpatient care. Emergency medicine in the UK has therefore remained dependent on inpatient specialties to help it provide a comprehensive service.

Unfortunately, the government clearly intends that in future many hospitals will not have the full range of core specialties,[1] and this will radically affect the sort of service their emergency departments can offer. In particular, many emergency departments will not be able to receive patients with major trauma or paediatric emergencies.

COLLEGE OF EMERGENCY MEDICINE

The formation of a UK College of Emergency Medicine has been widely welcomed, but has unfortunately occurred when the medical colleges have never been less influential. The government has deliberately sought to diminish the powers of the colleges, and is transferring many of their responsibilities to a body that it appoints—The Postgraduate Medical Education and Training Board. Furthermore, those who believe that the future of acute hospitals (and hence of emergency departments) is being influenced by our College will be disappointed to learn that this issue is being decided, without reference to our representatives,

[i] Major trauma, defined as an Injury Severity Score of >15.

by another government-appointed body, the National Leadership Network. This body includes several National Health Service managers, a former professor of endocrinology and a solitary emergency physician (who seems to represent no one but herself).

CONCLUSION

Our specialty has contrived to abandon a term ''A&E'' which was widely understood by the public and which emphasised our ability to manage all types of emergency. In its place we have adopted a term ''emergency medicine'', which means little to those outside our specialty, which fails to indicate our ability to manage all types of emergency and which risks confusing our specialty with acute medicine.

In addition, we have devalued minor trauma (which forms 60% of our workload), such that many outsiders now believe that this can be managed entirely by nurse practitioners. This misconception has been seized up on by Primary Care Trusts who wish to cap or reduce expenditure on emergency departments and who intend to achieve this by having minor trauma managed by salaried general practitioners or nurse practitioners.

In a move that will further destabilise our specialty, the government is promoting the idea that district hospitals (with a range of core specialties) should be abolished, and this will reduce the range of conditions that the emergency departments in these hospitals can deal with. This will confuse the public (who will have to learn exactly which emergencies their local emergency department can manage), and it will markedly reduce the number of emergency departments offering comprehensive emergency service. That there is no evidence base for this monumental change of policy should come as no surprise.[4] Nor is it unusual that this move directly contradicts another government policy: that of providing health services locally.

So what can be done? It is probably too late to change the name back to A&E, although one public body (the Post Office, briefly Consignia, did this when it realised it had made a mistake).[5] However, our College now needs to work hard explaining that our specialty deals with all emergencies (including minor trauma), and does so better than anyone else. Emergency physicians need to reclaim the management of minor trauma, and this element of our work needs to feature prominently in our postgraduate training and in our research efforts.

At the local level, emergency departments need to approach urgent care centre proposals cautiously, and in a way such that they retain their autonomy and most of their casemix. Government attempts to dismantle district hospitals (and hence their emergency departments) should be resisted, and to this end the College statement on what support services an emergency department requires is welcome.[5]

However, this is clearly a perilous time for emergency medicine in the UK. Our case-mix, our model of care, and the settings in which we practice are all under threat.

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